DARIN F. CLARK

MEDICAL DOCUMENTATION

LOGAN REGIONAL HOSPITAL
LOGAN, UTAH

RADIOLOGY REPORT (00084506) 213564-8

CLARK, DARIN ROOM:ER MR#:11-61-43 P TMB
EXAM DATE:11/22/92 AGE:025Y DOB:07/19/67

STUDY: CHEST

COMMENT: Initial examination of the chest demonstrates no evidence for pneumothorax, pulmonary contusion or major vascular injury.

Incidental note is made of Harrington rods which span the upper thoracic to the lower thoracic spine. The rods are threaded and have been placed in a manner to create compressive forces over the axial spine.

IMPRESSION: No acute abnormality of the chest is identified in the setting of trauma.

STUDY: CERVICAL SPINE CROSS-TABLE LATERAL VIEW

IMPRESSION: Initial cross-table lateral view is obtained and this shows normal alignment with no evidence for major injury.

STUDY: CERVICAL SPINE SERIES

COMMENT: Alignment of the cervical spine is normal. Disc spaces are well maintained. Prevertebral soft tissues are normal. There is no evidence for fracture or dislocation.

IMPRESSION: Normal cervical spine series.

STUDY: STERNUM

IMPRESSION: Views of the sternum show no evidence for fracture.

DOUGLAS D. CHILD M.D.

t11/23/92cn

11/23/1992 11:17am

Attachment # 1

Copy 1

LOGAN REGIONAL HOSPITAL RADIOLOGY REPORT (270099) 965631-5

CLARK, DARRIN FRONK ROOM:041 MR#:207500
EXAM DATE: 01/16/98 AGE:030Y DOB:07/19/67

STUDY: BRAIN AND CERVICAL SPINE MRI

CLINICAL HISTORY: Headaches. Prior Harrington rod placement.

TECHNIQUE: Brain images obtained using sagittal, axial, and coronal T1 and T2 weighted sequences.

FINDINGS: Midline structures maintained. Cervical cord unremarkable. Brain stem and cerebellum maintained.

Ventricles, cisterns, and sulci maintained. No abnormal intra- or extra-axial fluid collections. Gray/white matter differentiation unremarkable without focal white matter lesion. Normal vascular flow voids.

Posterior fossa structures maintained with midline fourth ventricle. Visualized cranial nerves. Possible small mucous retention cyst at the inferior medial aspect of the right maxillary sinus. Sinuses, mastoid air cells, and orbits maintained.

IMPRESSION: Essentially negative findings brain MRI as above.

STUDY: CERVICAL SPINE

TECHNIQUE: Sagittal and axial T1 and T2 weighted sequences obtained.

FINDINGS: A moderate amount of ferro magnetic artifact is present at the T2 level and below where the cord is not seen. What is seen of the vertebral body marrow signal is maintained, save for a mild decrease in height of C6 when compared with C5 and C7. No evidence for cerebellar tonsil descent. No paraspinous masses identified.

Abundant cerebrospinal fluid surrounds the cord at C2 with patent neuroforamina at C2-3.

Widely patent neuroforamina at C3-4, C4-5, C5-6, C6-7, and it appears to be patent at C7-T1, however, the artifact grows increasingly large inferiorly and poor visualization at C7-T1. Abundant cerebrospinal fluid surrounds the cord at all levels. No evidence for disc protrusion or significant degenerative change with osteophyte mass effect.

Attachment # 2

Copy 1

IMPRESSION: C6 is smaller in height than its neighbors above and below, suggesting prior compression or congenital/develpmental anomaly. Cervical cord maintained. Patent neuroforamina. No evidence for mass effect on the cord. Artifact inferiorly. Correlate clinically for treatment and followup.

TERRY J. BUCCAMBUSO, M.D.

TJB/tp T:01/16/98

DARIN CLARK December 20, 2012 EMG/rc
PERRY CLINIC

S: The patient is a 45-year-old male with bilateral femoropatellar pain.

This patient has had problems for the last several months, progressive, with pain in the retropatellar space with any kneeling, sitting with his knee bent, or going down hills. Both are equally a problem, and he knows of no definite injury. He does have some night pain when he sleeps with his knees bent.

O: On examination, this patient has some decreased tension in both quadriceps groups. The right knee is tender along the lateral femoropatellar joint and very tender with inhibition of the quads. He is also somewhat tender in the posteromedial joint line, but has a negative McMurray. He is stable to varus, valgus, anterior and posterior drawer.

The left knee is tender medially in the retropatellar space, and there is a popping on the lateral side of the patella. He also is painful with inhibition at a 4+ level, and he is tender mildly in the mid medial joint line.

Both of these painful episodes that occurred during the examination in the medial joint space are not common to him.

Evaluation of x-ray films, AP and lateral of the patella, show a well-ossified joint. The joint spaces are quite well preserved with some early narrowing of the medial side, and the femoropatellar joints are somewhat tilted laterally, but not pathologically. They are somewhat narrowed with very early beginning of osteophytes.

A: This patient shows evidence of chondromalacia patella with fibrillation of both femoropatellar joints. These are both related to bent-knee activities and presence of a weak quadriceps muscle.

P: We are going to put the patient in physical therapy, and I think that by strengthening we can get rid of a lot of his pain. He may come to injections in the future. Someday the medial joint line pain may need to be addressed with MRI's, because I think he is starting to get some degenerative changes in his menisci bilaterally.

E. Marlowe Goble, M.D./rc

Attachment #3

Perry Crawford
257-3809

Mountain West Physical Therapy

A Service of Cache Valley Specialty Hospital

Name Dawn Clark Date Dec 20, 12

Diagnosis PF Pain L > R
Medial Joint line tenderness

- [x] Evaluate and Treat
- [x] Therapeutic Exercise
- [ ] Ultrasound
- [ ] Gait Training
- [ ] Whirlpool
- [ ] Ice Packs
- [ ] Isokinetic Evaluation
- [ ] Neuromuscular Re-education Rehab
- [ ] Knee Brace
- [ ] Soft Tissue/Joint Mobilization
- [ ] Aquatic Therapy
- [ ] Electrical Stimulation
- [ ] Massage
- [ ] Iontophoresis/Phonophoresis
- [ ] Wound Care
- [ ] Hot Packs
- [ ] KT-1000 Arthrometer Evaluation
- [ ] Work Conditioning
- [ ] Orthotics
- [ ] ASTM
- [ ] Functional Capacity Evaluation
- [ ] Other

Return appointment with physician 4 weeks. Frequency/Duration

Frequency/Duration 1x-3x w/c

Comments: PF Program

R/O Meniscal tear

If Medial Joint line ↑ in Pain, refer back for MRI or Injection

Signature Eu Soh M.D.

2310 North 400 East, Ste B • North Logan, Utah 84341 • Phone (435) 787-9030 • Fax (435) 787-9033
169 North Spring Creek Pkwy., Ste 140 • Providence, Utah 84332 • (435) 755-8500 • Fax (435) 755-2836
1655 North 200 East, Suite 2 • North Logan, Utah 84341 • (435) 753-1844 • Fax (435) 753-2986
44 North 100 East • Preston, Idaho 83263 • (208) 852-4122 • Fax (208) 852-3512
451 West 600 North • Tremonton, Utah 84337 • (435) 257-3809 • Fax (435) 257-6347
1950 South Hwy. 89 • Perry, Utah 84302 • (435) 723-1902 • Fax (435) 723-1908

PHYSICAL THERAPY FOLLOW UP

NAME: Dawn Clarke Age: 45 DOB: 7/19/67 DATE: 1/21/13

DIAGNOSIS: (B) knee pain

SUBJECTIVE: PAIN LEVEL (Current): 0 1 2 3 (4) (5) 6 7 8 9 10 PAIN LEVEL (At Worst): 0 1 2 3 4 5 6 (7) (8) 9 10

Pt is ____ days/weeks/months S/P pt has received 4 PT treatments including modalities & then ex for quad/knee strength c/o severe pain to medial knees

OBJECTIVE:

ROM: WNL STRENGTH: 4-/5

GAIT: ☐ WNL ☑ Antalgic (min) mod/severe) ☐ Decreased Knee Ext (min/mod/severe) ☐ Decreased Knee Flex (min/mod/severe)

Demonstrates weakness in quads - esp c closed chain activities

PT ASSESSMENT:

☐ Patient is making appropriate progress in all areas towards therapy goals.
☐ Patient is progressing with their: ☐ ROM ☐ Strength ☐ Gait Pattern ☐ Other: ____
☑ Patient is having difficulty with: ☐ Achieving knee flexion ☐ Achieving knee extension ☐ Normalizing gait pattern ☑ Pain Control

Recommend follow-up c MD 2° no change on T in knee pain.

PT SIGNATURE 1/21/13 DATE

PHYSICIAN ASSESSMENT:

PLAN:

☐ CONTINUE WITH CURRENT REHAB: ____ x per week for ____ wks
☐ CHANGE CURRENT REHAB: ____
☐ FOLLOW UP WITH PHYSICIAN: ____
☐ Other: ____

COMMENTS: ____

PHYSICIAN SIGNATURE DATE

IHC

Logan Regional Medical Center
500 E. 1400 N.
Logan, Utah 84341

IHC

Patient Name	Sex	Birthdate	Age	Medical Record Number	Account Number
CLARK, DARIN F	MALE	07/19/67	36	116143	27686138

Admit Date / Time	Discharge Date / Time	LOS	Disposition
04/22/04 09:26 AM	04/22/04 09:26 AM	1	Home

Primary Pay Source	Secondary Pay Source
SELECT MED	

Attending Physician	Physician Number	Coder
DAVIS, DIRK	07239	Patti Falor

MDC Code	MDC Text

DRG Code	DRG Text

HCFA Weight	Average LOS	Financial Patient Type
		HIGH RISK PROCEDURES

Prin. DX	*Principal Diagnosis Text*
53011	REFLUX ESOPHAGITIS

DX Code	*Secondary Diagnosis Text*
53085	BARRETT'S ESOPHAGUS
53510	ATROPHIC GASTRITIS
5533	DIAPHRAGMATIC HERNIA
5368	DYSPEPSIA AND OTHER FUNCTIONAL DISORDER OF STOMACH
V153	PERSONAL HISTORY OF IRRADIATION

PX Code	*Procedure Text*	*Date*	*Surgeon*
4516	ESOPHAGOGASTRODUODENOSCOPY (EGD) WITH CLOSED BIOPSY	04/22/04	DAVIS, DIRK

CPT Code & Modifier(s)	*CPT Procedure Text*	*Date*	*Surgeon*
43239	EGD; BX, SINGLE/MULTIPLE	04222004	DAVIS, DIRK

Attachment # 4

Logan Regional Hospital

EGD Procedure Report

Patient: Mr. Darin Clark
Patient ID: DOB 7/19/67 11-61-43
Exam Date: 04/22/2004

Attending Physician: Dirk Davis M.D.
Referring Physician: JAN-ERIK SCHOW M.D.

INTRODUCTION:
36 year old male patient presents for an elective outpatient EGD. The indications for the procedure were abdominal pain, dyspepsia and GERD symptoms.

CONSENT:
The benefits, risks, and alternatives to the procedure were discussed and informed consent was obtained from the patient.

PREPARATION:
EKG, pulse, pulse oximetry and blood pressure monitored.

MEDICATIONS:
- Demerol 75 mg IV before the procedure
- Versed 5 mg IV before the procedure

PROCEDURE:
The endoscope was passed without difficulty under direct visualization to the 2nd portion of the duodenum. Retroflexion was performed in the cardia of the stomach.

FINDINGS:
ESOPHAGUS: Possible Barrett's esophagus was noted. A few cold biopsies were obtained.
GE-JUNCTION: There was a small hiatal hernia.
STOMACH: The stomach appeared normal.
DUODENUM: The duodenum appeared normal.

COMPLICATIONS:
There were no complications associated with the procedure.

IMPRESSION:
1. Possible Barrett's esophagus. [530.2]. A few cold biopsies were obtained.
2. Hiatal hernia. [553.3].
3. The stomach appeared normal.
4. The duodenum appeared normal.

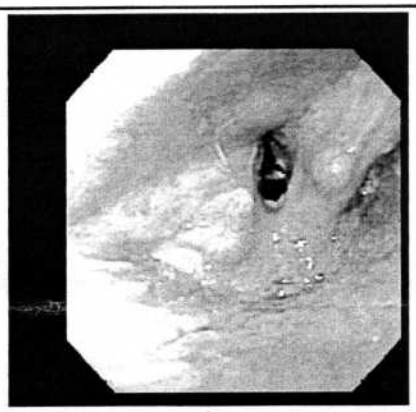
RECOMMENDATION:
- Follow-up on the results of biopsy specimens.
- Follow-up with JAN-ERIK SCHOW, M.D..
- Continue current medications.
- Follow-up with GI clinic as needed.

Logan Regional Hospital

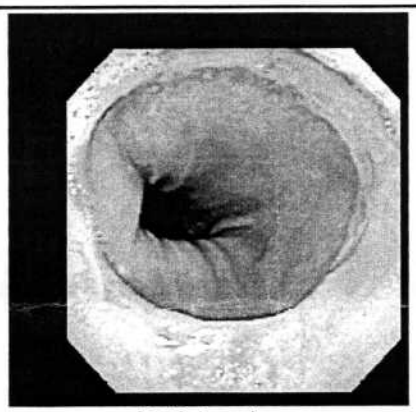
EGD Procedure Report

Patient: Mr. Darin Clark
Patient ID: DOB 7/19/67 11-61-43
Exam Date: 04/22/2004

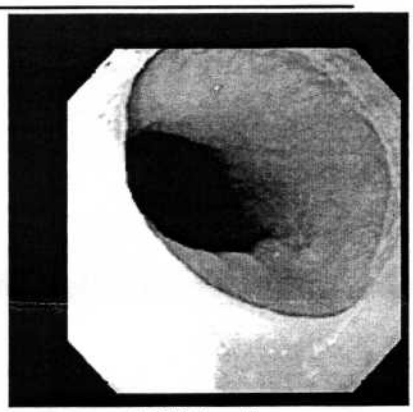
Attending Physician: Dirk Davis M.D.
Referring Physician: JAN-ERIK SCHOW M.D.



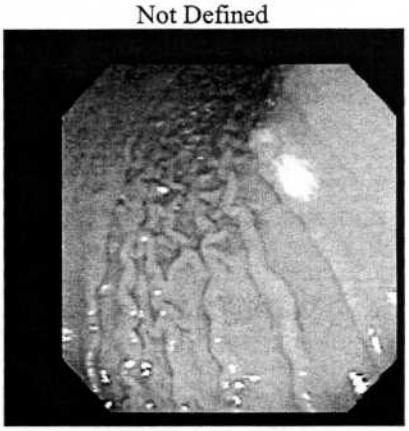
1
Not Defined



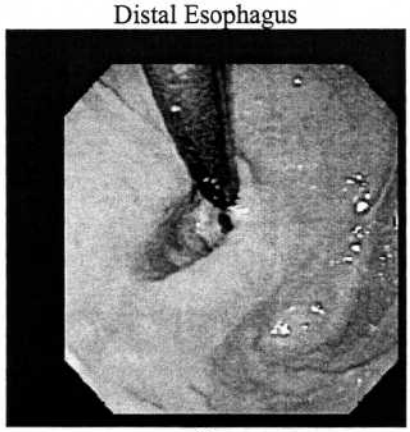
2 EG junction
Distal Esophagus



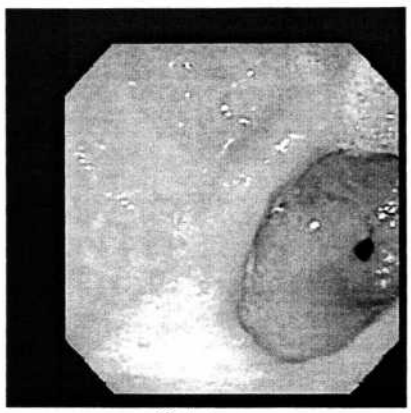
3 EG junction



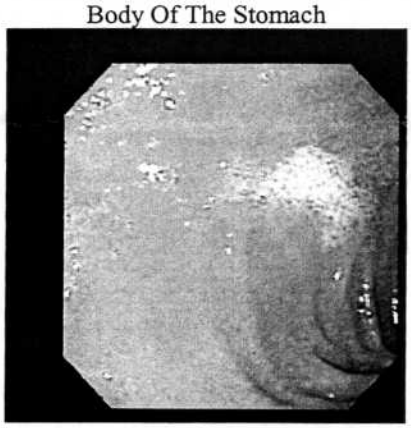
4
Body Of The Stomach



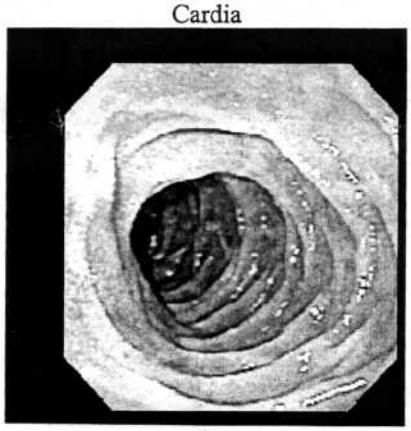
5
Cardia



6 Antrum
Antrum



7
Bulb



8
2nd Portion Duodenum

Dirk Davis M.D.

GT 4/2

LAB NO: **LRS-04-002052**
MMI #: 403078128
PATIENT NAME: **CLARK, DARIN FRONK**
DOB: 7/19/1967 36Y M

Date Obtained: 4/22/2004
Date Received: 4/22/2004

PHYSICIAN(S): Dirk R. Davis, MD Phone: 435-787-0270, Fax: 435-787-0262
Jan-Erik Schow, MD Phone: 435-257-2469, Fax: 435-257-2434

PATIENT INFO:
Specimen(s) Submitted: ESOPHAGEAL BIOPSY RULE OUT ESOPHAGITIS, METAPHAGIA

THIS IS AN AMENDED REPORT

Pre-op Diagnosis: Heartburn, screening.
Post-op Diagnosis: Rule out esophagitis, metaplasia.

FINAL DIAGNOSIS:
ESOPHAGEAL BIOPSY:
1. **SQUAMOUS MUCOSA WITH MILD REFLUX ESOPHAGITIS.**
2. **GASTRIC MUCOSA WITH MODERATE ACTIVE CHRONIC INFLAMMATION AND FOCAL PANETH CELL-LIKE METAPLASIA.**
3. **NO INTESTINAL METAPLASIA, DYSPLASIA OR CARCINOMA IDENTIFIED.**
4. **NO HELICOBACTER ORGANISMS IDENTIFIED.**

SNOMED T-CODE: T56000 T56000
SNOMED M-CODE: D530140 D530100

AMENDMENT COMMENT:
The purpose of this amended report is to convey findings of a special giemsa stain. A special giemsa stain shows no helicobacter type organisms, and the control material is stained appropriately. The diagnosis has been modified to reflect this finding. The remainder of this report remains unchanged.

GROSS EXAMINATION:
The specimen designated "Clark" consists of four tan to light brown irregular mucosal tissue fragments 0.3 to 0.4 cm in diameter each, toto (4).

MICROSCOPIC EXAMINATION:
Sections show squamous-type esophageal mucosa with elongation of vascular pegs, basal cell hyperplasia, and an increased number of intraepithelial inflammatory cells, predominantly lymphocytes, but including rare eosinophils and neutrophils. Gastric-type glandular mucosa contains a patchy mild chronic inflammatory cell infiltrate including eosinophils and neutrophils that extends into the glandular epithelium in several areas where there are reactive changes. Foci of Paneth cell-like metaplasia are noted. Distinctive goblet cell metaplasia characteristic of Barrett's mucosa, dysplasia, adenoma, or carcinoma is not identified. Although some cases of Barrett's esophagus are comprised exclusively of gastric-type glandular mucosa, correlation with anatomic site is needed. The inflammatory changes are compatible with reflux disease. A special Giemsa stain has been requested to better evaluate for Helicobacter organisms in the gastric mucosa; finding will be issued in a follow up report.

Matthew M. Kershisnik M.D.
Pathologist
Electronically signed 04/26/2004

MOUNTAIN WEST
Ear, Nose & Throat • Head & Neck

CURT R. STOCK, M.D.

D. TYKIE SKEDROS, M.D.

STEVEN M. KELLY, M.D.

SCOTT K. THOMPSON, M.D.

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1551 South Renaissance Towne Dr.
Suite 310
Bountiful, Utah 84010
Phone 801-295-5581,
801-292-3331
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Layton Office
2255 N. 1700 W.
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Layton, Utah 84041
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Fax 801-776-2534

Draper Office
114 East 12450 S.
Suite 206
Draper, Utah 84020
Phone 801-576-5930
Fax 801-576-5934

Brigham Medical Clinic
Thomas Matthews, MD
600 W. Hospital Rd.
Brigham City, UT

RE: Darin Clark
DOB: 7/19/1967

Dear Dr. Matthews,

Darin Clark, a 45 year-old male, was seen for a hearing evaluation on 8/21/12. He is a longstanding patient of this clinic. He wears bilateral hearing aids. He reported today that he is having more difficulty hearing, even with his hearing aids.

Otoscopy showed clear ear canals and intact tympanic membranes. Hearing was tested conventionally and reliability was considered good. Air and bone conduction thresholds indicated a mild sloping to severe sensorineural hearing loss bilaterally. SRT's (speech reception thresholds) were consistent with the audiometric test results. Speech discrimination was good at 92% in the right ear and 88% in the left ear at comfortable presentation levels. Tympanograms showed type A tracings and suggest normal middle ear pressure and function. Ipsilateral acoustic reflexes were present bilaterally.

The patient has a mild sloping to severe sensorineural hearing loss bilaterally. Hearing has slightly decreased compared to test results from 10/10/08. The patient's hearing loss is significant and the patient will have problems hearing sounds and speech in any environment without his hearing aids. With his hearing aids, the patient will still have difficulty understanding speech when there is background noise present, with multiple speakers, when the speaker is turned away from him, and when there is distance between him and the speaker. The patient will be able to hear the best in a quiet environment while speaking to one person who is facing him and in close proximity.

The test results were discussed with the patient. His hearing aids were checked and adjusted to meet real-ear targets in order to make the speech signal accessible to him. His hearing aids are from 2007. He could use more power, due to the decrease in hearing. He could also benefit from the features available in newer hearing aids. He was told to follow-up with you regarding these test results. We will continue to follow him regarding his hearing and hearing aids.

Thank you for the referral,

Niki L. Barwick, AuD
Doctor of Audiology

Attachment #5

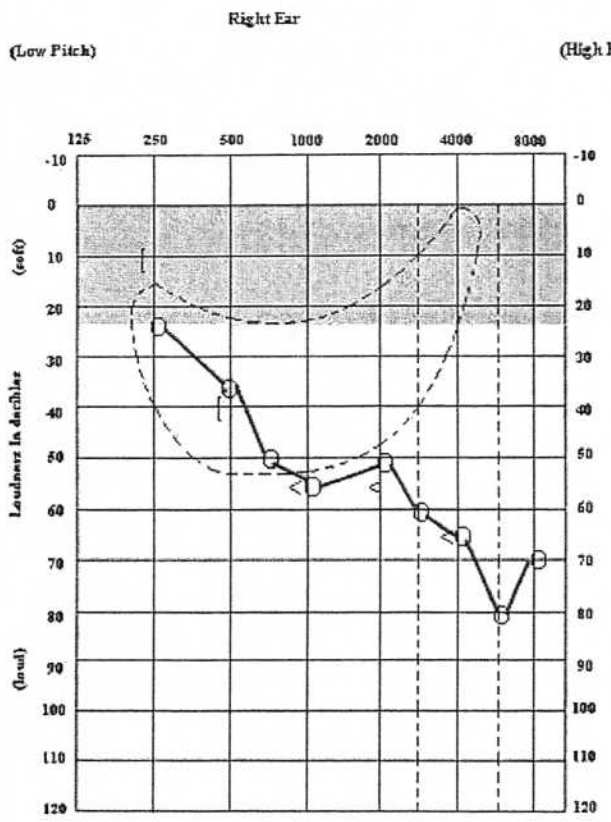
MOUNTAIN WEST
Ear, Nose & Throat · Head & Neck

AUDIOMETRIC REPORT

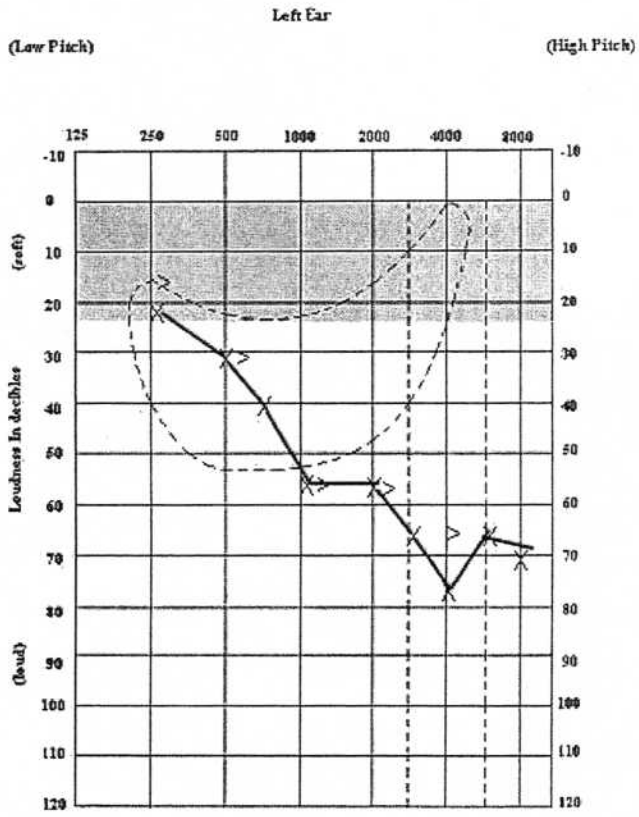
Audiometric Report:

Hearing aid candidate flag HA Candidate

Audiogram Right



Audiogram Left



Right PureTone Thresholds

	500	1000	2000	PTA Avg
AC	35	55	50	47

Left PureTone Thresholds

	500	1000	2000	PTA Avg
AC	30	55	55	47

Right Ear Speech Audiometry %

	Value
SRT	50 dBHL
Word Recog	92%
----Level	90 dBHL

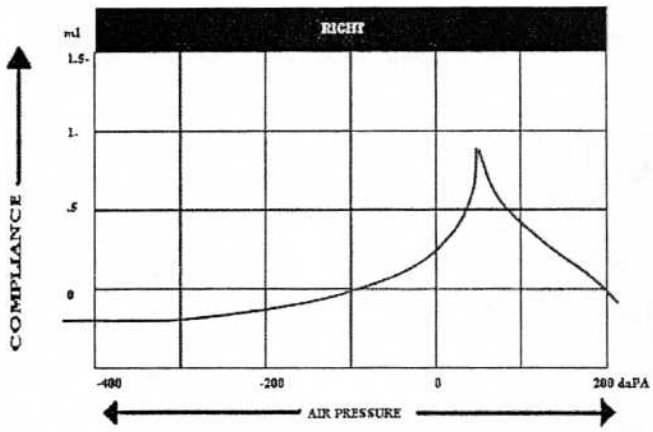
Left Ear Speech Audiometry %

	Value
SRT	45 dBHL
Word Recog	88%
----Level	85 dBHL

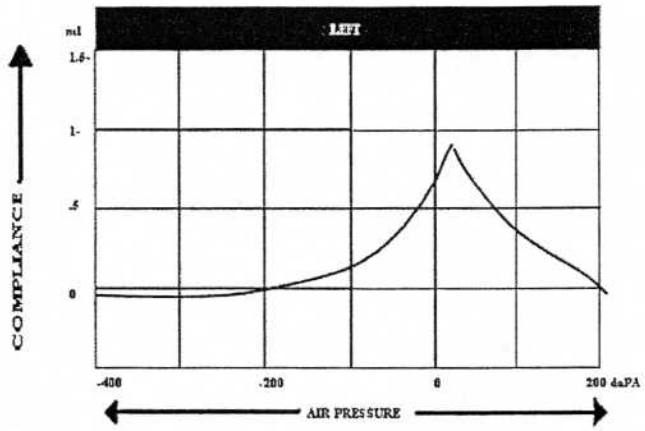
Test Reliability good
Transducer earphone
Response mode Standard
Tested by: Niki L. Barwick, AuD.
Hearing Aid Candidate Yes

Impedance Report Form:

Mid Ear Analyzer Right



Middle-Ear Analyzer Left



Physical Volume Right

	daPa	ml
Physical volume (cc)	1.6	
T1	95	0.7
Type	A	

Physical Volume Left

	daPa	ml
Physical volume (cc)	1.5	
T1	25	0.8
Type	A	

R Stapedius Reflex (HTL)

	1 K
Reflex Level (Ipsi)	90

L Stapedius Reflex (HTL)

	1 K
Reflex Level (Ipsi)	95

Audiology DX Codes 389.18 - Sensorineural

Mountain West ENT Codes Audiology 92550 Tymp Reflex and 92557 Basic Comrehensive Eval

Date: 11/28/12
Time: 1240

BRIGHAM CITY COMMUNITY HOSPITAL
950 SOUTH MEDICAL DR.
BRIGHAM CITY, UTAH 84302
Phone: (435) 734-4173 Fax: (435) 723-7437
Pathologist Norman O. Wahlstrom Jr., M.D.

*** OUTPATIENT REPORT ***

NAME:	**CLARK,DARIN F**	LOC:	G.LB
ACCT#:	G00701903002	AGE/SEX:	45/M
ATTEND DR:	Brigham City Community	STATUS:	REG REF
		DOB:	07/19/67

SPEC #: 1128:CBF:C00014R **COLL:** 11/28/12-0908 **STATUS:** COMP **REQ #:** 00360300
RECD: 11/28/12-0908 **SUBM DR:** Brigham City Community Hosp

ENTERED: 11/28/12-0908 **OTHR DR:**
ORDERED: COMP. METABOLIC, LIPID, PSA

	Test	Low	Normal	High	Flag	Reference
	COMP. METABOLIC					
	LIPID					
>	SODIUM		143			136-145 mEq/L
>	POTASSIUM		3.8			3.6-5.2 mEq/L
>	CHLORIDE		105			98-107 MMOL/L
>	CARBON DIOXIDE		24.5			21.0-32.0 mEq/L
>	GLUCOSE		90			70.0-110.0 mg/dL
>	BUN		13			7-20 mg/dL
	CREATININE/GFR					
>	CREATININE		1.0			0.9-1.5 mg/dL
>	GFR CAL		>60			
>	TOTAL PROTEIN		7.8			6.4-8.2 gm/dL
>	ALBUMIN		4.1			3.4-5.0 gm/dL
>	GLOBULIN		3.7			2.0-4.0 gm/dL
>	CALCIUM		9.5			8.8-10.4 mg/dL
>	BILI TOTAL		0.51			0.0-1.0 mg/dL
>	SGOT/AST			70	H	15-37 U/L
>	SGPT/ALT			122	H	30-65 U/L
>	ALK PHOS		82			45-150 U/L
>	TRIGLYCERIDES			409	H	30-200 mg/dL
	LDL CALCULATION IS NOT ACCURATE WHEN TRIGLICERIDES ARE GREATER THAN 400 MG/DL.					
>	CHOLESTEROL			266	H	0-200 mg/dL
>	HDL CHOLESTEROL		34			32-96 mg/dL
>	LDL-CALCULATED	TEST NOT PERFORMED				0-130
>	HDL/CHOL		7			1.0-10.0 mg/dL

RISK FACTOR FOR CHD

	HDL	*LDL*
LOW	*> 60*	*< 130*
MOD	*35 - 60*	*130 - 160*
HIGH	*< 35*	*> 160*

National Cholesterol Education Program (NCEP) Guidelines

Attachment #6

BRIGHAM CITY COMMUNITY HOSPITAL
950 SOUTH MEDICAL DR.
BRIGHAM CITY, UTAH 84302
Phone: (435) 734-4173 Fax: (435) 723-7437
Pathologist Norman O. Wahlstrom Jr., M.D.

*** OUTPATIENT REPORT ***

NAME: **CLARK,DARIN F** CONTINUED

Specimen: 1128:CBF:C00014R **Collected:** 11/28/12-0908 **Status:** COMP **Req#:** 00360300
Received: 11/28/12-0908 **Subm Dr:** Brigham City Community Hosp

Ordered: COMP. METABOLIC, LIPID, PSA

Test	Low	Normal	High	Flag	Reference
> PSA		0.81			0.00-4.00
Siemens' (Dade) Dimension Method.					

SPEC #: 1128:CBF:H00015R **COLL:** 11/28/12-0908 **STATUS:** COMP **REQ #:** 00360300
RECD: 11/28/12-0908 **SUBM DR:** Brigham City Community Hosp

ENTERED: 11/28/12-0908 **OTHR DR:**
ORDERED: HEMOGRAM

Test	Low	Normal	High	Flag	Reference
HEMOGRAM					
> WBC		5.0			3.60-10.60 K/mm3
> RBC		5.26			4.40-5.80 M/mm3
> HGB		16.2			13.3-16.9 gm/L
> HCT		44.8			40.0-51.2 %
> MCV		85.2			78.0-97.3 fL
> MCH		30.8			26.2-32.5 pg
> MCHC			36.2	H	32.0-36.0 g/dl
> RDW		13.5			11.3-15.6
> PLTS		232			140-400 K/mm3
> MPV		9.8			6.6-10.7 fl

Brigham City Community Hospital

EXPLANATION OF LAB RESULTS

We at the Brigham City Community Hospital Laboratory are pleased to be part of your health care team. We offer you this explanation of your lab results to help you understand and have confidence in this report. You have been sent two copies of your results, one for you, and one to share with your health care provider. The goal of this laboratory testing is to help you learn more about your body and identify potential problems early when treatment or lifestyle changes can be most effective.

Your report contains two elements, a blood chemistry analysis that includes a lipid (cholesterol) panel, glucose and electrolytes, and a blood cell count or CBC. Males will also have a PSA (prostate specific antigen) result. Please note that the normal range for each test is listed in the Reference column. If any lab result falls outside of this range, it will be listed in the Low or High column. If you have results that fall in the Low or High column they may indicate a medical problem, or may not be of any concern at all. Your physician is the most appropriate person to discuss these matters with. *PLEASE CONTACT YOUR HEALTH CARE PROVIDER WITH ANY QUESTIONS AND MAKE AN APPOINTMENT FOR FURTHER EVALUATION IF YOUR DOCTORS INDICATES THIS IS NECESSARY. IN THE EVENT YOU DO NOT HAVE A HEALTHCARE PROVIDER PLEASE CALL THE PHYSICIAN REFERRAL LINE (435) 734-4203 OR EMAIL PHYSICIANREFERRAL@MOUNTAINSTARHEALTH.COM*

CHEMISTRY TESTS

SODIUM AND CHLORIDE are regulated by the kidneys and adrenal glands. They are important for the functioning of nerves, muscles and most cells. Your doctor should evaluate any value outside the expected ranges.

POTASSIUM is controlled very carefully by the kidneys. It is important for the proper functioning of nerves and muscles, particularly the heart. Any value outside the expected range, high or low, requires medical evaluation. This is especially important if you are taking a diuretic (water pill) or heart pill (Digitalis, etc.)

GLUCOSE is a measure of the sugar level in your blood. High values can be associated with eating before the test and diabetes. If your fasting blood sugar is above the normal range, you should consult your doctor. If your blood sugar is over 200, even if you had recently eaten or have known diabetes, you should contact your physician.

BUN is a waste product produced in the liver and excreted by the kidneys. High values may mean that the kidneys are not working as well as they should. BUN is also affected by high protein diets, strenuous exercise, or dehydration (which raises the level) and pregnancy (which lowers it). Your doctor should evaluate high values.

CREATININE is another waste product that indicates how your kidneys are working. The amount present is not affected by the quantity of protein you eat. High values require medical evaluation, especially with high BUN levels. Low values are not significant.

TOTAL PROTEIN, ALBUMIN, and GLOBULIN: These are a general index of overall health and nutrition. Total protein is a measure of the protein circulating in your blood. Albumin is a small "carrier" protein, and globulin is the "antibody" protein important for fighting disease. Your doctor should evaluate any total protein, or globulin value outside normal range, or any low albumin.

CALCIUM is controlled by the parathyroid glands and the kidneys. This mineral is found mostly in bone, but is also important for proper blood clotting, and nerve, muscle, and cell activity. Your health care provider should evaluate any abnormal value.

BILIRUBIN TOTAL is the pigment (color) in bile. High levels may indicate liver disease or some other disorder that reduces the normal flow of bile and should be reported to your physician.
AST/SGOT AND ALT/SGPT are proteins called enzymes that aid various chemical activities within muscle, liver and heart cells. Injury to cells can release these enzymes into the blood. Damage from alcohol, heart attack, liver disorders and a number of related diseases are reflected in high values and should be evaluated by your doctor. Low values are probably not significant.

ALKALINE PHOSPHATASE (ALK PHOS) is an enzyme found primarily in bones and the liver. Expected values for this test are higher in pregnant women; otherwise, your physician should evaluate any high value. A low value is probably not significant.
CHOLESTEROL: a blood fat. High levels have been associated with increased risk of heart disease in some people. National research groups have shown an increased risk of developing heart disease when values exceed 200 mg/dL. The following guidelines have been developed from these studies:

- Everyone should try to get his or her cholesterol levels below 200. People that fall in this category have a low risk of developing heart disease.
- If your level is between 200 and 250, your risk of developing heart disease is increased.
- If your level is greater than 250 you have a high risk of developing heart disease. Consult your health care provider for advice on diets and medications to help you lower your risk.

HDL CHOLESTEROL: sometimes called the "good cholesterol", it is one of several types of fats that make up the total Cholesterol number. The higher your HDL number, the lower your risk of developing heart disease.
LDL CHOLESTEROL: sometimes referred to as "bad cholesterol", this is another of the fats included in the total Cholesterol number. Generally, you want this number to fall within the reference range.
TRIGLYCERIDE: a blood fat that is directly affected by what you have eaten. Triglycerides may remain at high values in your blood for up to 12 hours after you have eaten. However, even after eating, if your triglyceride number is higher than 500, you should consult your health care provider.
PSA (PROSTATE SPECIFIC ANTIGEN): a blood test for males that can indicate enlargement or cancer of the prostate. If the result is above the reference range, you should contact your doctor. PSA values are particularly helpful when done annually and followed over a period of years.

BLOOD CELL COUNTS (HEMOGRAM)

The HEMOGRAM measures three types of cells, white blood cells (WBC), red blood cells (RBC), and platelets (PLT).
WBC: may be increased during infections and other problems such as allergies, or decreased in other types of disease processes.
RBC: the cells that carry oxygen through your blood to the cells throughout the body.
HGB: Hemoglobin, the molecule inside the RBC that actually carries the oxygen. This test can be used to diagnose anemia or an unhealthy increase in blood volume.
HCT: The percentage of your blood volume that is made up of cells. This test is used in conjunction with hemoglobin to diagnose anemia or increased blood volume.
PLTS: Platelets, help in the blood's ability to clot.
MPV: Mean Platelet Volume, a measurement of platelet size.
MCV, MCH, MCHC, RDW: calculations used by doctors to help in the diagnosis of conditions such as anemia.

Intermountain Healthcare

Lab Results

Patient: CLARK, DARIN FRONK	**Home Phone:** (435) 279-3853	**DOB:** 07/19/1967
Address: 1315 RIVERVIEW DR	**Work Phone:** (801) 238-5355	**EMPI:** 403078128
GARLAND, UT 843129330	**Sex:** M	**MRN:** 116143

Comprehensive Metabolic Panel

	Test Status	Na	K	Cl	CO2	Anion Gap (Na Cl CO2)	Glucose	BUN
Last Ref. Range:		137-146	3.5-5.0	98-109	19-30	3-16	65-99	6-21
Units:		mmol/L	mmol/L	mmol/L	mmol/L	mmol/L	mg/dL	mg/dL
04/21/07.12:02	Final	143	3.7	103	26	14	90	14

Comprehensive Metabolic Panel (cont)

	Creatinine	GFR, Estimated	Ca	Prot	Albumin	Bili, Total	Alk Phos	ALT
Last Ref. Range:	0.8-1.3	>60	8.4-10.2	6.0-8.4	3.3-4.8	0.2-1.3	40-120	12-61
Units:	mg/dL	mL/min/1.73 sq m	mg/dL	g/dL	g/dL	mg/dL	U/L	U/L
04/21/07.12:02	1.3	>60	10.0	8.5 H	4.8	0.5	87	86 H

Comprehensive Metabolic Panel (cont)

	AST
Last Ref. Range:	16-50
Units:	U/L
04/21/07.12:02	43

04/21/2007.12:02 - Ordering/Requesting Facilty:Logan Regional Hospital, Logan, UT; Performing Location(unless otherwise noted):Logan Regional Hospital, Logan, UT

Vitamin B12

	Test Status	B12
Last Ref. Range:		193-982
Units:		pg/mL
04/21/07.12:02	Final	* >1000 H

* Comments

04/21/07.12:02 B12: Performed at Intermountain Central Laboratory, Murray, Utah

04/21/2007.12:02 - Ordering/Requesting Facilty:Logan Regional Hospital, Logan, UT; Performing Location(unless otherwise noted):Logan Regional Hospital, Logan, UT

Thyroid Stimulating Hormone

	Test Status	TSH
Last Ref. Range:		0.45-4.67
Units:		uIU/mL
04/21/07.12:02	Final	* 1.74

* Comments

04/21/07.12:02 TSH: Performed at Intermountain Central Laboratory, Murray, Utah

04/21/2007.12:02 - Ordering/Requesting Facilty:Logan Regional Hospital, Logan, UT; Performing Location(unless otherwise noted):Logan Regional Hospital, Logan, UT

CBC

	Test Status	WBC	RBC	HGB	Hct	MCV	MCH	MCHC
Last Ref. Range:		3.6-10.6	4.50-5.90	13.5-17.5	41.0-53.0	80.0-100.0	26.0-34.0	32.0-36.0
Units:		K/uL	M/uL	g/dL	%	fL	pg	g/dL
04/21/07.12:02	Final	6.4	5.50	16.9	47.7	86.6	30.6	35.4

CBC (cont)

	RDW	PLTS	MPV	Nucleated RBCs, Automated	Differential Type	Neut, Abs	Neut, Auto	Lymph %
Last Ref. Range:	11.3-15.6	150-400	6.6-10.1			1.8-6.8	36.0-66.0	24.0-44.0
Units:	%	K/uL	fL	/100 WBCs		K/uL	%	%
04/21/07.12:02	12.6	352	8.1	0.0	Automated	4.1	63.9	23.9 L

CBC (cont)

	Mono, Auto	Eos, Auto	Baso, Auto	Lymph, Abs	Mono, Abs	Eos, Abs	Baso, Abs
Last Ref. Range:	0.0-8.0	0.0-5.0	0.0-5.0	1.2-3.4	0.2-0.9	0.0-0.5	0.0-0.3
Units:	%	%	%	K/uL	K/uL	K/uL	K/uL
04/21/07.12:02	9.4 H	2.0	0.8	1.5	0.6	0.1	0.1

04/21/2007.12:02 - Ordering/Requesting Facilty:Logan Regional Hospital, Logan, UT; Performing Location(unless otherwise noted):Logan Regional Hospital, Logan, UT

RPR

	Test Status	RPR
Last Ref. Range:		NR
Units:		
04/21/07.12:02	Final	Nonreactive

04/21/2007.12:02 - Ordering/Requesting Facilty:Logan Regional Hospital, Logan, UT; Performing Location(unless otherwise noted):Logan Regional Hospital, Logan, UT

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Lab Results

Urinalysis

	Test Status	Collect Method, Ur	Color	Appear	Sp Gr, Ur	pH, Urine	Glucose, Ur	Ketones, Ur
Last Ref. Range:			NORMAL	NORMAL	1.003-1.035	5.0-8.5	NEG	NEG
Units:							mg/dL	mg/dL
04/21/07.12:03	Final	Clean Catch Specimen	Normal	Normal	>1.030	6.0	Negative	Negative

Urinalysis (cont)

	Nitrite	Hgb, Ur	Prot, Ur	Leuk Esterase
Last Ref. Range:	NEG	NEG	NEG	NEG
Units:				
04/21/07.12:03	Negative	Negative	Negative	Negative

04/21/2007.12:03 - Ordering/Requesting Facilty:Logan Regional Hospital, Logan, UT; Performing Location(unless otherwise noted):Logan Regional Hospital, Logan, UT

Drugs Of Abuse, Rapid Screen, Urine

	Test Status	Amphetamines	Methamphetamine	Barbit Scrn, Ur	Benzodiazepines	Cocaine	Methadone	Opiates
Last Ref. Range:		NEG	NEG	NEG	NEG	NEG	NEG	NEG
Units:								
04/21/07.12:03	Final	Negative	Negative	Negative	Negative	Negative	Negative	Negative

Drugs Of Abuse, Rapid Screen, Urine (cont)

	Synthetic Opioids	Cannabinoids, Ur	Comment
Last Ref. Range:	NEG	NEG	
Units:			
04/21/07.12:03	* Negative	Negative	* See Note

* Comments

04/21/07.12:03 Synthetic Opioids: (NOTE) INTERPRETIVE TEXT FOR Synthetic Opioids: Synthetic Opioids include Oxycodone, Hydrocodone, Hydromorphone and Oxymorphone.

04/21/07.12:03 Comment: (NOTE) INTERPRETATION OF DRUG SCREENS: This is an unconfirmed screening test and should be used for MEDICAL purposes only.
False positive and false negative results can occur with any screening test. When clinically indicated, specific drug identification
should be done by a more specific method such as GC/MS.

04/21/2007.12:03 - Ordering/Requesting Facilty:Logan Regional Hospital, Logan, UT; Performing Location(unless otherwise noted):Logan Regional Hospital, Logan, UT

Hepatic Function Panel

	Test Status	Prot	Albumin	Bili, Total	Bili, Conj	Bili, Unconj	Alk Phos	ALT
Last Ref. Range:		6.0-8.4	3.3-4.8	0.2-1.3	0.0-0.3	0.0-1.1	40-120	12-61
Units:		g/dL	g/dL	mg/dL	mg/dL	mg/dL	U/L	U/L
08/06/09.10:56	Final	7.9	4.8	0.5	0.0	0.3	74	59

Hepatic Function Panel (cont)

	AST
Last Ref. Range:	16-50
Units:	U/L
08/06/09.10:56	37

08/06/2009.10:56 - Ordering/Requesting Facilty:Logan Regional Hospital, Logan, UT; Performing Location(unless otherwise noted):Logan Regional Hospital, Logan, UT

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John R. Markeson, M.D.
James R. Taylor, M.D.

Gregg H, Wilding, M.D.
Thomas M. Matthews, M.D.
David G. Wilding, M.D

07-25-12

To Whom It May Concern:

Re: Darin F. Clark
DOB: 7-19-1967

Darin Clark has been seen either at our office or at the Nucor Building Systems Clinic, about every two weeks since January 2009. He has chronic pain in his knees and feet. The x-rays and other tests have been normal, and Naprosyn, an anti-inflammatory has not helped. He has been given a short course of prednisone, which helped a little bit. He has had swelling of his ankles and his knees at times. He has never been on narcotic medication for this pain, but it does decrease his mobility and his ability to be very active. Darin has also been seen for bouts of depression and anxiety. At times these have been quite severe. He also suffers from gastroesophageal reflux disease, tremors of his arms and legs, and has had pre diabetes on laboratory testing in the past. He has severe migraine headaches, which at times are quite incapacitating. He has had these headaches since age 27 and they are coming between twice a week and once a week. They often give him central blindness, decrease the hearing in his ears and he usually just has to go bed when he gets these kinds of headaches. He once was in a pain clinic for this but now just uses ibuprofen.

His current medications are Naprosyn 500 mg twice daily, Clonazepam 1 mg twice daily, Simvastatin 40 mg once a day, omeprazole 40 mg once a day.

Further questions can be addressed to me at the above address.

Sincerely,

Thomas M. Matthews, M.D.
Brigham Medical Clinic
TM/rh

Attachment #7